

Dental Insurance Enrollment/Change Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.

Name of Employer/Plan Sponsor: North Dakota Public Employees Retirement System	Group/Plan: 3328472	Agency/Department Name:	Agency/Department Number:
This change is due to: <input type="checkbox"/> Initial Eligibility Following Hire <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Late Entrant due to Change in Family Status* <input type="checkbox"/> Change Agency from _____ to _____			Effective Date of Coverage or Change: <input type="checkbox"/> Address Change <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Termination <input type="checkbox"/> Retirement

* A late entrant is an individual who is first enrolling for dental coverage after the first available opportunity.

Employee Name (last, first, middle initial)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth / /	Social Security #
Employee Address (street address, city, state, zip code)		<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated	<input type="checkbox"/> Married <input type="checkbox"/> Widowed Telephone Work () Home ()

Elect or Decline Coverage

Elect Dental Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family
Waive Dental Coverage	IF YOU DO NOT WANT COVERAGE, COMPLETE THIS SECTION. I have been given an opportunity to apply for Group Dental Insurance and have decided waive coverage for: (check all that apply) <input type="checkbox"/> myself <input type="checkbox"/> spouse only <input type="checkbox"/> child(ren) only <input type="checkbox"/> myself and entire family

Dependent Information

Complete for covered spouse and each covered child. Attach separate sheet if more room is needed.

Dependent Name (last, first, middle initial)	Relationship to Employee	Gender (F or M)	Date of Birth	Marital Status*	Child Status**	Add or Delete

* For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, Legally Separated.

** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.

Other Dental Coverage Information

Complete if you and/or any dependent have dental coverage with another insurer or carrier.

Employee/Dependent Name (last, first, middle initial)	Name and Address of Other Dental Insurer/Carrier	Policy/Plan Number	Effective Date	Other Dental Coverage Type
				<input type="checkbox"/> Single <input type="checkbox"/> Family
				<input type="checkbox"/> Single <input type="checkbox"/> Family

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW↓

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by CIGNA HealthCare, provided I am actively at work.

Employee's Signature	Date Signed / /
----------------------	--------------------

Enter your name, gender, date of birth, social security number, mailing address, marital status, and telephone numbers.

Elect Coverage

Select the level of coverage. If electing Employee + Spouse, Employee + Child(ren), or Employee + Family, complete spouse and dependent coverage information. If you are adding or dropping a spouse or dependent, ensure that you check the appropriate box.

Waive Coverage

Select who is waiving coverage.

Other Dental Coverage

Indicate if you and/or any dependent have other dental coverage.

You must sign and date this form for it to be valid.